

**Kentucky FY 2012
Preventive Health and Health Services
Block Grant**

Work Plan

Revised Work Plan for Fiscal Year 2012

Submitted by: Kentucky

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Executive Summary

This work plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Year 2012. It is submitted by the Kentucky Department for Public Health (DPH) as the designated state agency for the allocation and administration of PHHSBG funds.

Funding Assumptions: The total award for the FY 2012 Preventive Health and Health Services Block Grant is \$1,008,785 including the mandatory sex offense set aside. This amount is based on a funding update allocation table distributed by CDC in August, 2012.

Proposed Allocation and Funding Priorities for FY 2011

Sexual Assault-Rape Crisis (HO 15-35): \$97,025 of this total is a mandatory allocation to the Kentucky Department for Community Based Services (DCBS), which provides this funding to thirteen Kentucky Rape Crisis Centers and their statewide coalition to provide medical and legal advocacy services to victims of rape and other sex offenses.

Health Care Access (HO 1-6): \$50,000 of this total will be utilized by the Healthcare Access Branch of DPH in coordination with the Kentucky Physicians Care Program, a network of volunteer physicians, dentists, and pharmacies who provide free or discount services to the uninsured.

Community Health Action Teams (HO 7-10): \$319,619 will be utilized to support the infrastructure of the Healthy Communities Program in Kentucky by providing training and technical assistance to local coalitions to develop policy, environmental and systems change strategies that will impact population health. This will include building infrastructure for a worksite wellness council and training for small businesses.

Clinical Preventive Competency(HO 1-4): \$24,000 will be utilized to fund a Chronic Disease Initiative program which will emphasize the chronic disease self-management classes, competency of staff providing adult preventive exams and quality improvement initiatives and team led processes.

Chronic Obstructive Disease Program (COPD HO 24-10): \$15,000 will be used to fund capacity for the state burden document and state strategic plan and education for public health professionals and providers. Kentucky has one of the highest burden of prevalence, hospitalization costs and mortality from COPD and has no other source of funding.

Colon Cancer Prevention (HO 3-5): \$144,600 will be used to provide fund a 1.0 FTE program manager position a statewide awareness campaign, and pilot projects in local communities. Colon cancer is largely preventable with screening and Kentucky has a high prevalence and mortality rate.

Physical Activity Program (Adult HO 22-1 and Child HO 22-6): \$200,421 provides funding to local health departments for evidence based community physical activity programs and policy initiatives focusing on the built environment in order to impact individuals throughout the life continuum. This program places 100% of the funds out into the local communities through the local health departments.

Osteoporosis Program (HO 2-9): \$74,120 will be used to provide funding for .5 FTE for a Bone and Joint Coordinator and to select sites in local/district health departments in Kentucky to provide awareness and education on Osteoporosis. A Matter of Balance and Falls Prevention Coalitions are projects for this program.

Administrative costs associated with the Preventive Health Block Grant total \$84,000 which is 9.8% of the grant. These costs include funding 1 FTE to coordinate the preparation, annual reporting, evaluation and program meetings as well as communication with and holding required block grant meetings of the State Preventive Health Advisory Committee, and public hearings. This funding also support IT needs for reporting such as the Office of Information Technology/DataMart support.

The grant application is prepared under federal guidelines, which require that states use funds for activities directed toward the achievement of the *National Health Promotion and Disease Prevention Objectives in Healthy People 2010*.

Funding Priority: Under or Unfunded, Data Trend

Statutory Information

Advisory Committee Member Representation:

Advocacy group, College and/or university, Community health center, Community resident, County and/or local health department, Foundation, Managed care organization, Mental health organization, Minority-related organization, Research organization, Schools of public-health, Senior/adult serving organization, State health department, Volunteer organization

Dates:

Public Hearing Date(s):

9/21/2011

Advisory Committee Date(s):

9/21/2011

1/18/2012

Current Forms signed and attached to work plan:

Certifications: Yes

Certifications and Assurances: Yes

Budget Detail for KY 2012 V1 R0	
Total Award (1+6)	\$1,008,785
A. Current Year Annual Basic	
1. Annual Basic Amount	\$911,760
2. Annual Basic Admin Cost	(\$84,000)
3. Direct Assistance	\$0
4. Transfer Amount	\$0
(5). Sub-Total Annual Basic	\$827,760
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	\$97,025
7. Sex Offense Admin Cost	\$0
(8.) Sub-Total Sex Offense Set Aside	\$97,025
(9.) Total Current Year Available Amount (5+8)	\$924,785
C. Prior Year Dollars	
10. Annual Basic	\$0
11. Sex Offense Set Aside (HO 15-35)	\$0
(12.) Total Prior Year	\$0
13. Total Available for Allocation (5+8+12)	\$924,785

Summary of Funds Available for Allocation	
A. PHHSBG \$'s Current Year:	
Annual Basic	\$827,760
Sex Offense Set Aside	\$97,025
Available Current Year PHHSBG Dollars	\$924,785
B. PHHSBG \$'s Prior Year:	
Annual Basic	\$0
Sex Offense Set Aside	\$0
Available Prior Year PHHSBG Dollars	\$0
C. Total Funds Available for Allocation	\$924,785

Summary of Allocations by Program and Healthy People 2010 Objective

Program Title	Health Objective	Current Year PHHSBG \$'s	Prior Year PHHSBG \$'s	TOTAL Year PHHSBG \$'s
Chronic Obstructive Pulmonary Disease Program	24-10 Chronic obstructive pulmonary disease (COPD)	\$15,000	\$0	\$15,000
Sub-Total		\$15,000	\$0	\$15,000
Clinical Preventive Competency	1-3 Counseling about health behaviors	\$24,000	\$0	\$24,000
Sub-Total		\$24,000	\$0	\$24,000
Colon Cancer Prevention and Control Program	3-5 Colorectal cancer deaths	\$144,600	\$0	\$144,600
Sub-Total		\$144,600	\$0	\$144,600
Health Care Access	1-6 Difficulty or delays in obtaining needed health care	\$50,000	\$0	\$50,000
Sub-Total		\$50,000	\$0	\$50,000
Healthy Communities-Community Health Action Team (CHAT)	7-10 Community health promotion programs	\$319,619	\$0	\$319,619
Sub-Total		\$319,619	\$0	\$319,619
Osteoporosis Prevention and Education Program	2-9 Osteoporosis	\$74,120	\$0	\$74,120
Sub-Total		\$74,120	\$0	\$74,120
Physical Activity Program	22-1 Physical Activity in Adults	\$100,220	\$0	\$100,220
	22-6 Physical Activity in Children and Adolescents	\$100,201	\$0	\$100,201
Sub-Total		\$200,421	\$0	\$200,421
Rape Crisis Centers-Sexual Assault and Domestic Violence Program	15-35 Rape or attempted rape	\$97,025	\$0	\$97,025
Sub-Total		\$97,025	\$0	\$97,025
Grand Total		\$924,785	\$0	\$924,785

State Program Title: Chronic Obstructive Pulmonary Disease Program

State Program Strategy:

Goal: The Chronic Obstructive Pulmonary Disease Program (COPDP) is committed to reducing morbidity and mortality due to COPD in Kentuckians.

Priorities: The Kentucky Department for Public Health (DPH) in cooperation with multiple partners will develop, publish, and distribute the COPD Surveillance Document and the COPD state strategic plan. Both of these publications will be available on the DPH website for download.

In 2007, along with the Kentucky State legislature adopting a resolution addressing COPD, the Chronic Disease Branch established the Respiratory Disease Program which included the COPDP with funding from the PHHSBG to identify COPD as a chronic disease with substantial cost burdens to the patient, community, and to Medicaid.

The COPD Coalition Education and Public Awareness and Assessment and Treatment subcommittees planned and convened the first annual COPD Summit. The COPD Coalition also conducted a screening event at the Kentucky State Fair, promoted the COPD Learn More Breathe Better Campaign and held screening events with grant funds received by NHLBI with the COPD Foundation Mobile Spirometry Screening Unit in four eastern Kentucky locations, co-sponsored with the Tobacco Control Program four "Lunch-n-Learn" for primary care providers prior to COPD Awareness Month, and participated in the Pulmonary Symposium sponsored by the Kentucky Lung Association

Persons with COPD need to be aware of the risk factors and symptoms of their disease and encouraged to be diagnosed early to begin treatment to improve COPD symptoms. Patients should work in collaboration with their health care providers to help them manage their condition using best practice guidelines such as spirometry and appropriate medications.

Because smoking is the number one cause of chronic obstructive pulmonary disease (COPD), smoking cessation is an important component of managing COPD symptoms. COPD Program will also be working to encourage a policy and systems change for tobacco cessation to be covered by employers' health benefit packages. The COPD will also be able to utilize the Tobacco Coordinators at the local health departments to reach COPD patients who continue to smoke with their smoking cessation classes. On September 1, 2010 the Tobacco Control Program and Medicaid made available tobacco cessation medication and counseling benefits to Kentucky Medicaid members.

Primary Strategic Partners: Internal partners include Environmental Health, Healthcare Access, Health Promotion Branch (Tobacco Prevention and Cessation Program) and Medicaid Services. External partners include the American Lung Association, COPD Foundation, National Heart Lung and Blood Institute, Passport (MA Managed Care), local and district health departments, universities, Kentucky Medical Association (KMA), private physicians and the Centers for Disease Control and Prevention.

Evaluation Methodology: BRFSS data and hospitalization data will be used to evaluate progress toward achieving the primary goal of reducing morbidity and mortality related to COPD. Both data sources are available on an annual basis. Additional surveys will be utilized to collect data to identify education and awareness gaps in terms of symptoms, medication use, and self-management of COPD. One-page fact sheets and data documents will be updated every one to two years and it is anticipated that a burden document will be produced at least every five years.

State Program Setting:

Business, corporation or industry, Child care center, Community based organization, Community health center, Faith based organization, Home, Local health department, Medical or clinical site, Parks or playgrounds, Schools or school district, State health department, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO 24-10 Chronic obstructive pulmonary disease (COPD)

State Health Objective(s):

Between 12/2007 and 12/2014, Reduce the COPD hospitalization rate to no more than 50 per 10,000 population.

Baseline:

Baseline: 57 per 10,000 population in 2000 and 68.3 per 10,000 in 2004.

Data Source:

Kentucky Hospital Discharge Utilization Report completed annually.

State Health Problem:

Health Burden:

Chronic obstructive pulmonary disease (COPD) is the leading diagnosis coded as a cause of hospitalization in Kentucky when admissions for normal newborn and vaginal delivery and mental health are removed from the table. The age-adjusted death rate for COPD has increased 10%, from 53.5 per 100,000 in 2000 to 57.9 per 100,000 in 2005. KY has the fourth highest mortality rate from COPD in the nation. It is one of the most common respiratory conditions of adults and is the fourth leading cause of death in the United States and in Kentucky.

COPD is characterized by the presence of airflow obstruction due to chronic bronchitis and emphysema, two diseases that often coexist. (COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.) Most people with COPD are current or former smokers. There is no cure for COPD.

Smoking is the number one cause of COPD, and Kentucky continues to battle one of the highest prevalence smoking rates among adults with 28.2% of the adult population currently smoking according to the 2007 BRFSS. Persons with less than a high school education and income less than \$15,000 have a higher prevalence of current smoking status over 40% and are therefore disproportionately affected. Kentucky has no comprehensive clean indoor air legislation and all Kentuckians will be targeted for education about smoking and the risk of COPD. Smokers will be chosen as the disparate population due to their higher risk.

From 2001 total hospitalizations increased from 19,376 to 21,016 in 2006, an increase of 8.5%. However, in 2007 hospitalizations decreased to 19,670. The COPD hospitalization rate in Kentucky for 2006 was 50.0 per 100,000. Almost 50% of patients admitted with COPD must be re-hospitalized within the following year.

Cost Burden: Average charges for a COPD hospitalization have also increased to \$24,936 in 2007, although average length of stay has remained about the same (4.6 days in 2001 to 4.3 days in 2007). Simply multiplied the average costs for hospitalization in 2007 were over \$400 million. This does not

account for required regular medications, breathing treatments, nursing home admissions or indirect costs of early disability. The average age is 65 for a person hospitalized in Kentucky for COPD (DRG 88). According to KY Inpatient Discharge claims 2007, Medicare is the primary payor (46%) for all hospitalizations with Medicaid (20.1%) and all other payers (33.9%). As Kentucky ages the cost burden for COPD is expected to increase and will have an enormous impact on Medicare.

Target Population:

Number: 4,314,113

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, White

Age: 25 - 34 years, 35 - 49 years, 50 - 64 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 1,198,731

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: US Census Bureau, KY Hospitalization Data and KY BRFSS

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Guide to Community Preventive Services (Task Force on Community Preventive Services)

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Model Practices Database (National Association of County and City Health Officials)

National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: Learn More Breathe Better Campaign, National Heart Lung and Blood Institute (www.nhlbi.nih.gov)

Best Practice in COPD: HEDIS and Beyond 2006(AHRQ)

Global Initiative for Chronic Obstructive Lung Disease (GOLD)

Joint Commission Certificate for Distinction for Chronic Obstructive Pulmonary Disease

American College of Physicians Clinical Recommendations for COPD

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$15,000

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$5,000

Funds to Local Entities: \$0

Role of Block Grant Dollars: Start-up

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

75-99% - Primary source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 1 – Monitor health status

Objective 1:

COPD Data Summaries

Between 10/2011 and 09/2012, The COPD Program Manager in collaboration with the COPD coalition will publish 2 existing or newly created data summary reports.

Annual Activities:

1. COPD Fact Sheet

Between 10/2011 and 09/2012, Develop a one page COPD fact sheet/summary of prevalence, hospitalization and mortality data for use by all partners in the state.

2. COPD Burden Document

Between 10/2011 and 09/2012, Work in collaboration with the KY Office of Health Policy, the KY Lung Association, the COPD steering committee and the KY BRFSS program to create a document that describes the burden of COPD in Kentucky which can be posted on the DPH website for access by providers, organizations and the public.

Essential Service 3 – Inform and Educate

Objective 1:

COPD Best Practice

Between 10/2011 and 09/2012, the Kentucky COPD Program in collaboration with the steering committee and the KY Lung Association will conduct one annual COPD Summit to provide training on COPD best practices.

Annual Activities:

1. COPD Summit

Between 12/2011 and 09/2012, The COPD program in collaboration partners will hold an annual state COPD Summit to provide training on COPD best practices.

2. Evaluation of COPD training modules

Between 06/2012 and 09/2012, Online evaluations and surveys will be developed through the TRAIN online system in collaboration with Workforce Development in order to analyze the impact of training.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Integrated Tobacco Cessation Message

Between 10/2011 and 09/2012, the Kentucky Respiratory Disease Program in collaboration with the Kentucky Tobacco Control Program will establish two integrated program activities and related to COPD and smoking.

Annual Activities:

1. Pharmacotherapy Provider Education

Between 10/2011 and 09/2012, In cooperation with the Kentucky Tobacco Control Program, engage and educate providers on reimbursement for recommended pharmacotherapy for smoking cessation.

2. Health Underwriters Project

Between 10/2011 and 09/2012, The COPD Program using the Tobacco Program Coordinator will provide one toolkit to the Kentucky Association of Health Underwriters to encourage Kentucky employers to provide tobacco cessation coverage as part of employee insurance plans.

Essential Service 5 – Develop policies and plans

Objective 1:

Support policies and plans related to COPD

Between 10/2011 and 09/2012, The COPD Program will identify **two** methods of supporting policy and plans in order to decrease the burden of COPD in Kentucky.

Annual Activities:

1. COPD Strategic Plan

Between 10/2011 and 09/2012, Work in collaboration with the Kentucky COPD coalition, partners, and the University of Kentucky to develop a Kentucky COPD strategic plan which will be posted on the KDPH website and disseminated to partners.

2. Restriction on smoking in public places

Between 10/2011 and 09/2012, Work in collaboration with the Tobacco Control Program , the Center for Smoke Free Policy and collaborative partners to obtain restrictions on smoking in work and public places.

State Program Title: Clinical Preventive Competency**State Program Strategy:**

GOAL: The Chronic Disease Initiative will focus on increasing collaboration and integration of chronic disease programs both within the Department for Public Health and with external partners. Special focus will be to enhance the capacity of health professionals and other partners to utilize best practice guidelines for chronic disease care and disease management and moving patients with chronic disease into and through the continuum of care through patient navigation in order to decrease disability and death.

PRIORITIES: Health Care Reform has established priority areas in Clinical Preventive Services and Health Services, which included both access and barrier issues in primary and preventive health care. Many disparities remain and the intent is to eliminate as many of these disparities as possible. Attention to prevention and quality will demonstrate improved health care delivery and outcomes through an emphasis on:

- *Evidence-based decision support tools for providers
- *Support of patient self-management as a core element
- *Patient Navigation through the healthcare system
- *Multidisciplinary health care teams and collaborative efforts

Primary Strategic Partners:

Internal: State Programs for Tobacco Control, Obesity and Nutrition, Physical Activity, Heart Disease and Stroke, Osteoporosis and Arthritis, COPD and Asthma, Oral Health, Colon Cancer and Breast and Cervical Cancer, and Diabetes Prevention and Control, Health Care Access Branch, Department for Medicaid Services, Department for Aging and Independent Living and Worksite Wellness.

External: Kentucky Medical Association, Humana and Passport (Medicaid Managed Care) Health Plans, Health Care Excel (state QIO), Universities of Louisville and Kentucky, State Office of Minority Empowerment, local and district health departments, Federally Qualified Health Centers, faith based communities and the Free Clinic Association.

Role of the PHHSBG: Provided startup funds in FY 2008 for a Chronic Disease Initiative beginning with a consistent message addressing chronic disease called "Everything Counts". This program will now be managed through a collaborative approach in the Chronic Disease Prevention Branch. The specific activities will be to develop partnerships with internal and external groups and partners as listed above. Selection and distribution of preventive care and self-management evidence based materials and support information will be expected. NACDD Chronic Disease Competencies will be promoted to local/district health department staff in order to assist with accreditation needs. The Chronic Disease Program is located within the Division of Prevention and Quality Improvement/Chronic Disease Prevention Branch.

Evaluation Methodology: The effectiveness of the program will be evaluated internally through reporting and surveys related to the Unnatural Causes DVD, CDSMP program, as well as following KY BRFSS data related to risk factors, chronic diseases, and disability. Additional data from Medicaid, BRFSS and the Office of Health Policy will be shared and reviewed. Categorical state plans and burden documents will be examined and utilized as a measurement of progress.

State Program Setting:

Business, corporation or industry, Community based organization, Local health department, Senior residence or center, State health department, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO 1-3 Counseling about health behaviors

State Health Objective(s):

Between 10/2007 and 09/2012, Between October 2007 and September 2012, increase the number of coordinated state plans from zero to one.

Baseline:

Baseline zero coordinated chronic disease plans.

Data Source:

KDPH strategic plans

State Health Problem:

Health Burden:

Chronic diseases are the cause of many of the disabilities and complications that Kentuckians endure throughout their lives. In Kentucky cardiovascular disease, cancer, diabetes, and chronic obstructive pulmonary disease are more prevalent compared to the rest of the nation. Almost one quarter (23%) of Kentucky adults rate their general health status as fair or poor. Approximately one in 7 persons has diabetes, with 9.9% of the population already diagnosed. Hypertension prevalence in Kentucky according to BRFSS 2007 is 30%. Kentucky Cancer Registry Data and SEER Data note that Kentucky has a higher mortality rate than the national average from cancer. According to the BRFSS survey 2009, approximately 16% are uninsured across the state. Kentucky is divided into 15 Area Development Districts and these rates are Area Development District dependent.

The high rates of obesity, lack of physical activity and tobacco use contribute to the chronic disease burden in Kentucky. However, there is also a high statistical correlation with the burden of chronic disease and poverty, lack of education and lack of usual source for health care. According to World Health Organization "poor people and those with less education are more likely to maintain risk behavior". Access to health care and a medical home are extremely important strategies in the battle against disability and early death from chronic disease. It is possible to delay deaths and disability from chronic disease by several decades through successful interventions in middle and older age, thereby avoiding both productivity loss and health burden.

Pre-existing conditions and co-morbidities affect patient response to treatment and may impact cancer treatment decisions. Among middle-aged men, the prevalence of chronic obstructive pulmonary disease in cancer patients is more than twice the prevalence in cancer-free men. Prevalence rates of hypertension and arthritis are significantly higher among middle-aged women within one year of diagnosis of cancer compared with those who are cancer free. (NHIS-2003)

Cost Burden: The burden of treating chronic disease is borne by all citizens in the Commonwealth of Kentucky. Approximately 270 million Medicare dollars and 340 million Medicaid dollars were spent on chronic diseases attributable to obesity, according to the 2003 Kentucky Obesity Epidemic Report. Obesity is a risk factor for diabetes, cardiovascular disease, cancer and arthritis. According to the KY Tobacco Control Program there is a cost burden of approximately \$1.5 billion each year in smoke-attributed medical expenses, including \$487 million on Medicaid medical costs. Lost productivity losses are estimated at over \$238 million each year.

Target Population:

Number: 3,046,951

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Number: 1,208,500
Ethnicity: Non-Hispanic
Race: African American or Black, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: US Census Bureau Data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
Model Practices Database (National Association of County and City Health Officials)
National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: Care Without Coverage - Institute of Medicine

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$24,000
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$14,400
Funds to Local Entities: \$19,000
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 3 – Inform and Educate

Objective 1:

Integrated health promotion and chronic disease messaging

Between 10/2011 and 09/2012, The Chronic Disease Initiative Coordinator will maintain 2 training methods on a consistent message impacting chronic disease prevention and control for health professionals, community leaders and lay health workers in Kentucky.

Annual Activities:

1. Stanford Chronic Disease Self-Management Training

Between 12/2011 and 09/2012, Work in collaboration with the Arthritis/Osteoporosis Coordinator and the Department of Aging and Independent Living to provide Chronic Disease Self Management Training to lay leaders in the state.

2. Unnatural Causes Training

Between 10/2011 and 01/2012, Utilize remaining copies of "Unnatural Causes" DVD purchased in 2009 for distribution to local and district health departments in Kentucky, universities, hospitals and other organizations and monitor use and impact on knowledge of health equity competency of health professionals in the state.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Chronic Disease Integration Collaborative

Between 10/2011 and 09/2012, The Chronic Disease Prevention Branch will conduct **4** integration meetings between the Health Promotion Branch, the Chronic Disease Prevention Branch and additional partners as developed through collaborative processes.

Annual Activities:

1. Healthy Communities

Between 10/2011 and 09/2012, Program Coordinators in the Health Promotion Branch and the Chronic Disease Prevention Branch will collaborate to fund and provide technical assistance to the Healthy Communities Initiative.

2. Patient Navigation

Between 10/2011 and 09/2012, The Chronic Disease Initiative Coordinator will evaluate two Chronic Disease Programs to integrate patient navigation activities with.

Essential Service 8 – Assure competent workforce

Objective 1:

Registered Nurse Role Expansion at the local health department

Between 10/2011 and 09/2012, The Chronic Disease Initiative Program Lead through contract will maintain **one** training program for Adult Preventive Health Exams through the Regional Training Center and a cooperative program with the Department for Medicaid Services.

Annual Activities:

1. Regional Training Center

Between 10/2011 and 09/2012, Online training modules will be completed by Registered Nurses applicants for the expanded role process, followed by a face to face training and six month preceptorship in the local community.

2. Evaluation of effectiveness

Between 10/2011 and 09/2012, Certificate of completion of requirements will be issued from the Kentucky Department for Public Health in a cooperative agreement with the Regional Training Center prior to performing and billing for the Adult Preventive Physical Exam.

State Program Title: Colon Cancer Prevention and Control Program

State Program Strategy:

Goal: Reduce the burden of colon cancer in Kentucky by decreasing colorectal cancer incidence and mortality rates through education and awareness and increased screening rates.

Priorities: Develop and enhance existing partnerships which will address colon cancer on both a state and local basis. Develop a process to communicate the importance of colon cancer screening so that clear consistent messages using evidence based guidelines are utilized. Identify barriers to colon cancer screening on a local level and improve access and awareness.

In the 2008 Kentucky legislative session, House Bill 415, which provides for development of a colon cancer screening program for the uninsured was passed and is now codified into statute as KRS 214.540. Unfortunately, funding was not appropriated due to budget issues in Kentucky. It is well known, that screening reduces mortality both by decreasing incidence (removing polyps before they are cancer) and by detecting a higher proportion of cancers at early, more treatable stages. Lack of funding has not prevented considerable efforts from taking place in the state over the past three years. An active and collaborative partnership was formed under the guidance of the Colon Cancer Screening Program Advisory Committee which meets monthly. This partnership has leveraged small amounts of funding and in-kind services to increase public awareness and education about colon cancer screening as well as increase access to screening for the uninsured.

Efforts to make cancer screening, information, and referral services available and accessible are essential for reducing incidence and mortality from colorectal cancer. Rates for colon cancer screening have steadily increased in the 5 years that the PHHSBG has been funding comprehensive cancer control education in the state with a special focus on colorectal cancer. In 2001 Kentucky had the lowest colorectal cancer screening rate as compared to other states according to national BRFSS data. Kentucky has now moved to a screening rate of 63.7% which has moved the state up to thirtieth highest state screening rates in the US. Additional factors such as improved Medicare and Medicaid coverage in the state have affected this increase in screening as well as national partners such as the CDC Screen for Life program and statewide partners efforts.

The Department for Public Health (DPH) Colon Cancer Control Program is partnering with the Kentucky Cancer Program with 15 regional offices and the Kentucky Cancer Consortium as well as private foundations such as the Colon Cancer Prevention Project to provide a statewide awareness and public outreach campaign. Internally the program is providing outreach and education to all 30,000 state health employees through a March colon cancer awareness campaign.

Primary Strategic Partners:

Internal partners: Health Promotion Branch- Tobacco Control, Obesity, Physical Activity, Worksite Wellness, Healthy Communities, KY Breast and Cervical Cancer Program, Office of Health Equity, Office of Health Policy and the Department for Medicaid Services.

External partners: Colon Cancer Prevention Project, Kentucky Cancer Consortium, American Cancer Society, Kentucky Cancer Program, Kentucky Medical Association, Kentucky Hospital Association, Federally Qualified Health Center network and local/district health departments.

Role of PHHSBG Funds: The role of the Block Grant in this program is to support one FTE for the Colon Cancer Program and to allocate funds to one project areas for local outreach and education with the use of matching funds for screening the uninsured.

Evaluation Methodology: Local/district health departments are required to submit a budget and plan prior to receiving funds detailing objectives, strategies and activities that will be provided for colon cancer prevention. The pilot site will be visited at least once during the year and success stories will be solicited

from these activities. BRFSS, Kentucky Cancer Registry and SEER data will be used to evaluate long term progress toward achieving the primary goal of reducing incidence and mortality from colon cancer. The program manager will summarize and analyze data from these sources in order to document progress and will provide an annual report to the legislature as required by statute.

State Program Setting:

Community based organization, Community health center, Local health department, Medical or clinical site, State health department, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Colon Cancer Program Manager

State-Level: 65% Local: 25% Other: 10% Total: 100%

Total Number of Positions Funded: 1

Total FTEs Funded: 1.00

National Health Objective: HO 3-5 Colorectal cancer deaths

State Health Objective(s):

Between 10/2007 and 12/2015, Decrease colon cancer death rate in Kentucky to no more than 18.5 per 100,000 persons in the state.

Baseline:

25.3 per 100,000 persons in 1996 and 24.1 per 100,000 in 2004

21.23 aggregated for 2002-2006 age adjusted rates.

19.93 aggregated for 2004-2008 age adjusted rates.

Data Source:

Kentucky Cancer Registry.

State Health Problem:

Health Burden:

In Kentucky, as in the US, colorectal cancer is the second leading cause of cancer death after lung cancer when figures for both men and women are totaled. It is the third cause of cancer death for men after lung and prostate cancer and the third leading cause of cancer death for women after lung and breast cancer. According to the Kentucky Cancer Consortium age adjusted colorectal cancer incidence rates for 2002-2006 in Kentucky were 58.0 compared to the U.S. rate of 50.5.

Contributing factors such as tobacco use, obesity, and nutrition as well as certain geographic, economic and educational barriers exist in Kentucky. The age-adjusted mortality rate for colorectal cancer is higher for African Americans and Appalachian Area Development Districts. According to the Kentucky Cancer Registry, the age adjusted mortality rate for African American males is 30.7 compared to white males at 25.7. The age adjusted mortality rate for African American females in Kentucky is 28.8 compared to white females in Kentucky at 17.4. Appalachian Area Development District age adjusted mortality rates range from a low of 18.14 in one district to a high of 25.09 in another district indicating that appropriate interventions and strategies considering culture and health literacy are necessary to make an impact on mortality rates and incidence rates.

A report in 2007 from the Kentucky Cancer Consortium indicates that lack of education has a high correlation with not obtaining screening and late stage diagnosis. Kentucky BRFSS data for 2008 indicates that those persons over the age of 50 who are college graduates report having a sigmoidoscopy or colonoscopy at at 73.5% while those with a high school education or GED have a 60.8% screening rate. The burden of colon cancer rests disproportionately on the lower income and less educated population in Kentucky. This also may create a significant burden on the Medicaid system in Kentucky as well.

According to the Kentucky Cancer Registry, over 2,500 Kentuckians are diagnosed with colon cancer each year and each year more than 900 die from this disease. Many of these cases are invasive, late-stage cancers, which are more expensive to treat, often without success. Colorectal cancer is almost 90% preventable by removing polyps before they develop into cancer. Additionally, the more localized the cancer, the better the person's chance of surviving longer.

Cost Burden: Approximately half (1378) of all colon cancers diagnosed in Kentucky each year are late stage disease. It costs an average of \$30,000 to treat each case of early stage colon cancer and an average of \$120,000 to treat each case of late stage colon cancer. This is \$90,000 more in direct treatment costs for each case of late stage colon cancer. If only 200 new cases of colon cancer were diagnosed at an early stage in one year the cost savings would be \$18 million dollars in direct treatment alone. More importantly increased colon cancer screening which removes polyps before they become cancer will reduce both state and personal economic burden, indirect costs of treatment and diminish lost years of productive life.

Target Population:

Number: 1,300,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, White
Age: 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Number: 143,976
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, Native Hawaiian or Other Pacific Islander
Age: 50 - 64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: US Census Bureau, state BRFSS data and Kentucky Cancer Registry

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: American Cancer Society - 2008 Cancer Screening Guidelines

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$144,600
Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$45,000

Funds to Local Entities: \$60,000

Role of Block Grant Dollars: Start-up

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

75-99% - Primary source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 3 – Inform and Educate

Objective 1:

Increase awareness of colorectal cancer screening

Between 10/2011 and 09/2012, The Colon Cancer Program Manager will maintain 4 methods of colon cancer awareness and messaging in Kentucky with special emphasis in Appalachia and African American populations.

Annual Activities:

1. Colon Cancer Awareness Minigrants

Between 10/2011 and 09/2012, at least one local/district health departments in Kentucky will receive minigrants to implement colon cancer prevention and/or screening awareness activities utilizing a pre-approved list of evidence based strategies.

2. State or Regional Colon Cancer Forum

Between 10/2011 and 09/2012, The Kentucky Colon Cancer Program in partnership with the Kentucky Cancer Consortium and the Kentucky Cancer Program will provide one state or regional cancer summit with a focus on colon cancer.

3. Kentucky State Fair Healthy Horizons

Between 10/2011 and 09/2012, The Colon Cancer Program Clinical Nurse will participate in Healthy Horizons with distribution of information on colon cancer screening and awareness and utilize the Kentucky Educational Colon for interactive education.

4. Kentucky Educational Colon Tour

Between 10/2011 and 09/2012, The Kentucky Department for Public Health in partnership with the Colon Cancer Prevention Project and the Kentucky Cancer Program will continue to promote a statewide campaign through an interactive walk through of the super colon which will be enhanced by having public health staff and other professional staff present to answer questions and navigate to appropriate colon cancer screening.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Kentucky Colon Cancer Program

Between 10/2011 and 09/2012, The Colon Cancer Program Manager will provide staff support for development of the Kentucky Colon Cancer Screening Program to **at least 3 partnerships or activities developed through** the Kentucky Colon Cancer Advisory Committee required by KRS 214.540-544.

Annual Activities:

1. Kentucky Colon Cancer Advisory Committee

Between 10/2011 and 09/2012, The Colon Cancer Program Manager will provide staff support at the monthly meetings of the Colon Cancer Screening Advisory Committee including maintenance of minutes as required by statute.

2. Colon Cancer Data System Workgroup

Between 10/2011 and 09/2012, The Colon Cancer Program manager will serve as a facilitator/staff member of the Data System Workgroup by providing meeting space, planning, materials, minutes and support for development and testing of a web based data system.

3. Colon Cancer Screening Program Website

Between 10/2011 and 09/2012, The Colon Cancer Program manager will continue to add appropriate public awareness messaging, provider resources and toolkits and additional links and updates to the state colon cancer prevention and screening website in collaboration with the Colon Cancer Screening Program Advisory Committee and the Workforce Development Branch.

Essential Service 5 – Develop policies and plans

Objective 1:

Colon Cancer Screening Awareness

Between 10/2011 and 09/2012, The Colon Cancer Program in collaboration with the Colon Cancer Advisory Committee will maintain **63.7%** colon cancer screening rate by colonoscopy or sigmoidoscopy of individuals over the age of fifty who are permanent residents of Kentucky and respond to the BRFSS survey.

Annual Activities:

1. Outreach and Education

Between 10/2011 and 09/2012, Distribute and evaluate colon cancer screening messages for Kentuckians at the state and local level.

2. Provide technical assistance to pilot sites

Between 10/2011 and 09/2012, The program manager will provide materials, connect pilot sites with state and national resources, and make site visits to determine effectiveness of the programs.

Objective 2:

Develop annual report for legislature and the public.

Between 10/2011 and 09/2012, The Kentucky Cancer Program Manager in cooperation with the state Colon Cancer Screening Program Advisory Committee will publish **one** annual report as described by KRS 214.540-544.

Annual Activities:

1. Annual Report Development

Between 10/2011 and 09/2012, An annual report including current burden, mortality and screening rates, activities of the program and partners and accomplishments will be developed.

2. Distribution of the Annual Report

Between 01/2012 and 09/2012, The annual report will be distributed to the advisory committee, Commissioner of Public Health, Secretary of the Cabinet, Legislative Research Commission, Legislative Health and Welfare Committee, and be available to the general public per KRS 214.540-544.

Essential Service 8 – Assure competent workforce

Objective 1:

Education and Workforce Development

Between 10/2011 and 09/2012, The Colon Cancer Clinical Nurse will review **two** evidence based training methods for colon cancer screening updates for clinical professionals.

Annual Activities:

1. Patient Navigation

Between 10/2011 and 09/2012, Identify and evaluate a patient navigation model for best practice in pilot sites.

2. Provide one clinical update on colon cancer screening

Between 10/2011 and 09/2012, The Colon Cancer Program Manager and Program Clinical Nurse will work with a physician champion to update a taped presentation on current screening recommendations, methods and referral process which is available for Continuing Education.

State Program Title: Health Care Access**State Program Strategy:**

GOAL: To increase access to primary episodic medical care for the uninsured by creating a network of providers and to increase the ability of Kentuckians who are uninsured to receive needed medications.

Priorities: The Kentucky Physician Care Program (KPCP) is part of the Health Kentucky Network and is facilitated by partnership with the Health Care Access Branch within the Kentucky Department for Public Health (DPH). The program consists of state and private partners who donate their time and materials to provide free one time routine care to low income uninsured citizens of the Commonwealth.

The process of this program includes the facilitation of a toll free hotline maintained at the Kentucky Department for Public Health in the Health Care Access Branch. Professional staff are available to answer calls and make referrals to a participating provider. Additionally, in 2009 the Kentucky Legislature passed a law establishing a Kentucky Prescription Assistance Program in the state which is also managed by the Health Care Access Branch. There are now over 400 Kentucky Prescription Assistance Program satellite sites throughout Kentucky where a client may receive free assistance in receiving medications through pharmaceutical companies. Trained volunteers or staff assist the client with access to databases for prescription assistance forms and help with the sometimes cumbersome details for these programs.

Role of the PHHSBG: is to provide funding through the Health Care Access Branch (HCAB) to Health Kentucky, Inc., a nonprofit charitable organization that coordinates a statewide network of volunteer providers through the Kentucky Physician's Care Program. There are multiple providers throughout the state who have volunteered to participate in this program. The introduction of the Kentucky Prescription Assistance Program through the HCAB as mandated by the Kentucky Legislature has provided additional benefits to clients who are in need of medications. The burden of unemployment and the economy continues to impact the 16.2% of Kentuckians who have no health insurance. PHHSBG will be utilized by Health Kentucky, Inc. in recruitment efforts of volunteer physicians, dentists, and pharmacies.

The Kentucky Department for Public Health contributes funding for approximately 4.5 FTE to this program for the operation of the hotline and for the staffing of the KPCP help desk as well as supporting 3 professional staff as Community Organizers for the Kentucky Prescription Assistance Program. There are over \$500,000 of state general funds invested for these activities. In addition, the indirect cost of office space, supplies, telephone, which is substantial, is also provided by the Department for Public Health.

Partnerships:

Internal: Department for Community Based Services, Department for Medicaid Services, Local Health Departments.

External: Health Kentucky, Kentucky Medical Association, Kentucky Pharmacy Association, Kentucky Primary Care Association, Foundation for A Healthy Kentucky, Kentucky Prescription Assistance Satellite sites, Free Clinic Association.

Evaluation Methodology

The effectiveness of the program will continue to be evaluated through the amount of phone calls received, number of clients served and number of referrals accepted by providers annually in order to evaluate reach to uninsured adults in Kentucky. BRFSS data on Health Care Access questions such as lack of health care coverage, usual source of care and care delays will be evaluated for baseline numbers of access issues. Health KY will conduct surveys of volunteer physicians, dentists and providers regarding the operation of the program to determine satisfaction. Cost benefit analysis of the KPCP program in terms of number of clients served and relative value will be captured.

State Program Setting:

Community based organization, Community health center, Faith based organization, Local health department, Medical or clinical site, State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO 1-6 Difficulty or delays in obtaining needed health care**State Health Objective(s):**

Between 10/2000 and 12/2020, Reduce to no more than 10 percent, the proportion of individuals/families who report that they did not obtain all of the health care that they needed.

Baseline:

13.8 percent in 2000 and latest data from the KY BRFSS is 17.2 percent in 2010 which may be reflected in the economic status of the nation and the increase in uninsured or underinsured.

Data Source:

Kentucky Behavior Risk Factor Surveillance Survey completed annually

State Health Problem:**Health Burden:**

Many low income Kentucky adults have no access to basic primary health care and many could not afford to purchase their prescription drugs. The effect of untreated chronic disease such as diabetes, asthma, COPD and heart disease and stroke, many of which are more prevalent in Kentucky creates both an economic and health burden on the individual, family and community.

According to KY BRFSS data for 2010 approximately 16.9% of adults in Kentucky have no source of health care coverage. In Kentucky, 16.7% of respondents to the survey do not think of one person as their medical doctor or usual healthcare provider. 17.2% or almost two out of every ten persons stated they have difficulty obtaining medical care in the past 12 months due to cost.

According to the Bureau of Economic Analysis (2010) Kentucky ranks 47th lowest in the nation for per capita income. The Economic Research Service of the USDA classifies fully 1/3 of Kentucky counties (43 of 120) as being persistent poverty counties. Approximately 23% of the states residents are below the poverty level and another 8% are between 100-138% of the poverty level. Educational attainment has been historically low in Kentucky with half of Kentucky's counties classified as "Low Education Counties" and only 20% attaining at least a Bachelor's Degree.

Kentucky has the 3rd highest percentage of persons reporting some disability in the United States, 17.1% (726,400) and ranks in the bottom third of the nation for persons reporting poor or fair health according to the 2008 American Community Survey (www.disabilitystatistics.org).

When these health problems are coupled with episodic care and no insurance, the person may seek unnecessary care in a hospital emergency room. There is a burden to the individual, to communities and to the Commonwealth as a whole in unnecessary emergency room visits and late stage disease interventions. There is also the burden of cost to the individual in reduction of necessities of living such as food, utilities and shelter when deciding whether to seek simple medical care.

Target Population:

Number: 568,514
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:

Number: 568,514
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: US Census Bureau and Kentucky BRFSS

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
Model Practices Database (National Association of County and City Health Officials)
National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: Care Without Coverage (Institute of Medicine)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$50,000
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$10,000
Funds to Local Entities: \$0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
Less than 10% - Minimal source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 7 – Link people to services**Objective 1:****Linking the Uninsured with Access to Health Care**

Between 10/2011 and 09/2012, The Health Care Access Branch will maintain **two** methods of linking the uninsured with health care and prescription assistance.

Annual Activities:**1. Expand the Kentucky Physicians Care Program network**

Between 10/2011 and 09/2012, Health Kentucky will strengthen and expand the network by enrolling additional free clinics, Federally Qualified Health Centers and private providers in the network.

2. Reporting Reach

Between 10/2011 and 09/2012, The Health Care Access Branch will monitor and report the number of calls received, clients served and referrals provided and numbers from the state funded Prescription Assistance Program.

State Program Title: Healthy Communities- Community Health Action Team (CHAT)

State Program Strategy:

Goal: The Healthy Communities Program in Kentucky is a multi-faceted program initially developed in 2009 through a collaboration of partners in the Health Promotion Branch and the Chronic Disease Prevention Branch in order to create infrastructure for community environments where safety, Wellness and effective prevention strategies are available. The overarching goal is to support local health programs, systems and policies to achieve healthy communities.

Priorities: The Kentucky Department for Public Health in cooperation with multiple partners will establish the following: 1) Provide a broad-based networking opportunity for building community coalitions; 2) Disseminate and provide training on evidence-based prevention programs; 3) Provide an annual Healthy Community conference; 4) Improve the use of data and surveillance at the community level in order to assist communities to prioritize strategies; 5) Develop a statewide strategic Healthy Community Plan

Primary Strategic Partners:

The Healthy Community Program has several strategic partners, both internal and external who will assist with the development and implementation of the program. Internal partners include BRFSS, Tobacco Control, Obesity, Arthritis/Osteoporosis, Worksite Wellness, Diabetes, Physical Activity and Heart Disease and Stroke Programs in KDPH as well as Coordinated School Health, Dept of Medicaid Services and the Department of Aging and Independent Living. External partners include the Foundation for a Healthy Kentucky, Kentucky Transportation Cabinet, University of Kentucky Area Health Education Centers, University of Kentucky Health Smoke Free Policy and Research, Kentucky Department of Education, Kentucky Injury Prevention Research Center, Kentucky Health Department Association and their respective health departments and community-based hospitals and clinics.

Role of PHHSBG Funds: The role of the PHHSBG in this program is to provide funding to local health departments to implement strategies addressing infrastructure to build coalitions at the local level. There are two separate categories of funding. The largest amount of funding will go to all 57 local and district health departments who must complete seven mandatory strategies and develop local coalitions. The second funding stream will be integrated with objectives and funding using two sources of state funding Tobacco Settlement, and Osteoporosis as well as the federal Healthy Communities funding for 3 pilot sites.

Evaluation Methodology: Evaluation methods will include assessment of community coalitions through site based visits, receipt and review of reports, reach and engagement of local partners, and implementation of the seven mandatory strategies as well as fiscal reporting. Also evaluated will be numbers of evidence based strategies including smoke free schools and places of business, biking paths, hiking trails, and access to healthy foods. In addition, the attendance at the Healthy Community Annual Conference with post conference evaluation and ongoing surveys will be completed. BRFSS data will also be monitored annually for improvement in nutrition, physical activity and decreased smoking rates.

State Program Setting:

Business, corporation or industry, Child care center, Community based organization, Community health center, Faith based organization, Home, Local health department, Medical or clinical site, Parks or playgrounds, Schools or school district, Senior residence or center, State health department, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Worksite Wellness Coordinator

State-Level: 20% Local: 0% Other: 0% Total: 20%

Total Number of Positions Funded: 1

Total FTEs Funded: 0.20

National Health Objective: HO 7-10 Community health promotion programs**State Health Objective(s):**

Between 04/2008 and 09/2020, Increase the proportion of communities in Kentucky that have established a Healthy Communities Coalition addressing multiple Healthy People objectives through policy, systems and environmental change who provide reporting to the KY Department for Public Health.

Baseline:

In 2010 there were 7 communities with established coalitions providing reporting on outcomes to the KY Department for Public Health.

Data Source:

KY Healthy Communities Program

State Health Problem:**Health Burden:**

Chronic Disease is both a health and economic burden to Kentucky. When trended over several years Kentucky has ranked among the top ten states with the highest prevalence for Diabetes, Heart Disease, Tobacco use, COPD, Cancer, Arthritis and Obesity. Much of this burden can be attributed to the same risk factors of lack of physical activity, exposure to tobacco, poor nutrition and lack of preventive screenings. Over 800,000 residents of Kentucky are disabled due to various mental and physical problems.

According to BRFSS data from 2009, Kentucky has an obesity prevalence of 28.7% and an additional 40.4% of all Kentucky adults are overweight. Obesity rates are exceptionally high among blacks (38.8%) and lower income Kentuckians (38.1%). An additional 40.4% of all Kentucky adults are overweight.

Only 44% of adults in Kentucky get the recommended amount of physical activity and only 18% of Kentuckians meet the 5-a-day recommendation for fruits and vegetable consumption. The overall smoking rate in Kentucky continues to be high at 28.2% as compared with 19.7% in the U.S.

The primary social determinants of health inequity in Kentucky include high rates of poverty, low levels of educational attainment, and somewhat limited access to health care services in rural areas of the state or those who are uninsured in any area. According to the Bureau of Economic Analysis Kentucky ranks 46th lowest in the nation for per capita income. The Economic Research Service of the USDA classifies fully 1/3 of Kentucky counties (43 of 120) as being persistent poverty counties. Poverty risks cross all age groups in Kentucky, with children being the most vulnerable. Approximately 22% of the states residents are below the poverty level and another 29% are between 100-138% of the poverty level. Educational attainment has been historically low in Kentucky with half of Kentucky's counties classified as "Low Education Counties" and only 17.1% attaining at least a Bachelors Degree.

In 2009 approximately 16% of Kentucky residents have no insurance, but that rate rises to over 30% for certain areas or population groups in the state. Although impressive strides have been made in enrolling children into the state Medicaid program there are still wide variations in population groups.

Kentucky's chronic disease burden consistently points to 4 identifiable priority populations which may require specialized consideration in the development, marketing and implementation of strategies to address chronic disease and risk factors among Kentucky citizens. Those priority populations are Appalachian residents, youth, urban African- Americans and low-income/low education groups. Although there will be focus on these priority groups the best approach to Healthy Communities will be through interventions that enable the healthy choice to be the easy choice through policy and systems change.

Target Population:

Number: 4,314,113

Ethnicity: Hispanic

Race: African American or Black, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 946,900

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: US Census Bureau, KY BRFSS Program, USDA Economic Research

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Guide to Community Preventive Services (Task Force on Community Preventive Services)

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Model Practices Database (National Association of County and City Health Officials)

National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Promising Practices Network (RAND Corporation)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$319,619

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$185,157

Funds to Local Entities: \$270,401

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 1 – Monitor health status

Objective 1:

Data Sources

Between 10/2011 and 09/2012, The Healthy Communities Coordinator in collaboration with the internal Healthy Communities Team will identify **two** methods of training on data sources for determining community needs.

Annual Activities:

1. County Level Health Data

Between 10/2011 and 09/2012, Provide training on County Level Health Data in cooperation with the Foundation for a Healthy Kentucky and Kentucky Health Department Directors at the annual Healthy Communities Conference through expert panel presentation and focused discussion groups.

2. Using Data to Activate and Motivate

Between 10/2011 and 09/2012, Working in collaboration with internal and external partners provide a statewide videoconference or webinar on using data to prioritize policy and systems change strategies.

Objective 2:

Change Tool

Between 10/2011 and 09/2012, The Healthy Communities Coordinator in collaboration with the internal Healthy Communities Team will obtain **one** training on the CHANGE tool instrument as developed by the CDC for use with the Healthy Communities Program.

Annual Activities:

1. CHANGE TOOL TRAINING

Between 10/2011 and 09/2012, The Healthy Communities Coordinator and the Chronic Disease Director will support two ACHEIVE communities and will attend training on the CHANGE tool.

2. CHANGE Tool Review

Between 10/2011 and 09/2012, The Healthy Communities Coordinator and the Chronic Disease Coordinator will provide a training on the CHANGE tool through the ACHEIVE community mentors.

Essential Service 3 – Inform and Educate

Objective 1:

Healthy Community Tools

Between 10/2011 and 09/2012, The Healthy Community Coordinator in collaboration with the internal Healthy Community Team will establish **3** methods of educating the public and professionals on the Healthy Community Program in Kentucky.

Annual Activities:

1. Healthy Community website

Between 10/2011 and 09/2012, A Healthy Community website will be established and updated within the KY Department for Public Health.

2. Use of a list-serve for updating information

Between 10/2011 and 09/2012, A list serve which can be widely promoted and used to disseminate information will be developed for the Healthy Communities program.

3. Healthy Community Conference

Between 10/2011 and 09/2012, there will be one annual conference focusing on education and updates for collaborative partners in the Healthy Communities process.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Healthy Community Coalitions

Between 10/2011 and 09/2012, Local and District Health Departments in collaboration with the KDPH internal Healthy Community team will increase the number of local Healthy Community Coalitions reporting on outcomes from their coalitions from seven to **57**.

Annual Activities:

1. Create infrastructure

Between 10/2011 and 09/2012, Provide funding to local health departments through plan and budget and/or RFP process for the development of Healthy Community Coalitions.

2. Integration with Chronic Disease/Health Promotion

Between 10/2011 and 09/2012, Internal KDPH programs will work together to create opportunities for shared meetings at both the state and local level.

Essential Service 5 – Develop policies and plans

Objective 1:

Local policy and plans

Between 10/2011 and 09/2012, The Healthy Community Coordinator in collaboration with local Healthy Community Coalitions and the internal Healthy Community Team will collect **two** reporting measurements from funded communities related to local policy, environmental and systems change to improve community health.

Annual Activities:

1. Active Coalitions

Between 10/2011 and 09/2012, Number of Healthy Community Coalitions who provided a list of partners and at least one set of minutes from their coalitions.

2. Number of policy or environmental change strategies

Between 10/2011 and 09/2012, Success stories from the Healthy Community Coalitions will be collected.

Objective 2:

Supporting Strategic Plan

Between 10/2011 and 09/2012, The KDPH internal Healthy Community Team in collaboration with statewide partners will develop **one** Coordinated Chronic Disease Prevention and Health Promotion state plan supporting Healthy Communities.

Annual Activities:

1. Engage internal and external partners

Between 10/2011 and 09/2012, Identify and engage partners in the strategic planning process.

2. Virtual and face to face meetings

Between 10/2011 and 09/2012, Provide venue for meetings and communication process to establish input on goals, objectives and activities for the state plan.

3. Review of strategic plan

Between 10/2011 and 09/2012, A draft of the state strategic plan will be disseminated to internal and external partners as well as leadership for review and final approval.

Essential Service 9 – Evaluate health programs

Objective 1:

Complete annual Healthy Communities Program Evaluation

Between 10/2011 and 09/2012, the internal Healthy Communities Team in collaboration with funded partners will analyze three reporting methods for the Healthy Communities Process.

Annual Activities:**1. Webinar Training**

Between 10/2011 and 09/2012, Four webinars supporting capacity and training for Healthy Communities leaders will be made available by the Chronic Disease Director and Healthy Communities Coordinator.

2. Health Impact Assessment

Between 10/2011 and 09/2012, The Worksite Wellness Coordinator will provide training on Health Impact Assessment to funded communities.

3. Evaluation of Healthy Communities Conference

Between 10/2011 and 09/2012, Through the TRAIN component of Workforce Development Branch, attendees at the annual conference will be given the opportunity to evaluate the effectiveness of the conference.

State Program Title: Osteoporosis Prevention and Education Program**State Program Strategy:**

Goal: The Osteoporosis Prevention and Education Program (OPEP) is a multigenerational program created to raise community and provider awareness of the causes, prevention, diagnosis and treatment of osteoporosis. The goal of OPEP is to reduce the prevalence of osteoporosis through prevention strategies and promotion of early detection and treatment, resulting in fewer fractures due to osteoporosis and reduced mortality.

Priorities: The Kentucky Department for Public Health in cooperation with multiple partners will establish the following: 1) Provide a broad-based community education program to educate the public about prevention, diagnoses and treatment options for osteoporosis; 2) Develop a network to disseminate evidence-based prevention programs related to bone health and falls prevention; 3) Educate health care providers and professionals to improve prevention, diagnosis, and treatment of osteoporosis; 4) Create a resource network for dissemination of information to consumers and health care professionals on osteoporosis; and 5) Improve the use of data and surveillance to monitor osteoporosis and falls prevention in Kentucky.

In Kentucky, legislation was enacted in 2006 to establish a statewide multigenerational osteoporosis prevention and education program with an annual budget of \$90,000. This osteoporosis funding has provided initial startup monies for the program with ongoing awareness and educational opportunities for the public, training for community partners to deliver evidence-based prevention programs, promotion of clinical guidelines for osteoporosis treatment and diagnosis to health care providers and the purchase of two Bone Density Heel Scan machines. The Osteoporosis Program coordinator shares duties for the Arthritis Program. Salary is provided with 1/2 PHHSBG funds and 1/2 state funds. This is a perfect complement of programmatic oversight because Chronic Disease Self-Management and Arthritis Foundation Exercises are an important approach to controlling the complications of Osteoporosis.

Primary Strategic Partners:

The Osteoporosis Program has several strategic partners, both internal and external who will assist with the development and implementation of the program. Internal partners include Adult and Child Health Improvement, Oral Health Program, Coordinated School Health, Medicaid, Healthy Start in Child Care Program, Kentucky Commission on Women, Wellness and Health Promotions Branch, Chronic Disease Prevention Branch, and the Department of Aging and Independent Living. External partners include University of Kentucky Area Health Education Centers, University of Kentucky Health Education through Extension Leadership (HEEL), Humana, Kentucky Department of Education, Kentucky Injury Prevention Research Center, Traumatic Brain Injury Association of Kentucky, local and district health departments and community-based hospitals and clinics.

Role of PHHSBG Funds: The role of the PHHSBG in this program is to provide funding for 1/2 FTE to coordinate the program and to provide funding to strategic pilot programs in local communities to implement strategies addressing bone health and prevention of osteoporosis. Local health departments are provided approved evidence based osteoporosis prevention and strategies with which to write a plan and budget and as appropriate work with a coalition in order to provide access to physical activity and healthy foods which are primary prevention factors for Osteoporosis.

Evaluation Methodology: BRFSS data and hospitalization data will be used to evaluate progress toward achieving the primary goal of reducing the proportion of adults with osteoporosis. These data sources correspond with the Healthy Kentuckians 2020 objectives related to osteoporosis and chronic back conditions. In addition, the program will be evaluated using results of pre and post surveys and functional fitness assessments for participants attending evidence-based programs in the community as well as reporting from Falls Prevention Coalitions in funded sites.

State Program Setting:

Business, corporation or industry, Community based organization, Community health center, Faith based organization, Local health department, Medical or clinical site, Schools or school district, Senior residence or center, State health department, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Osteoporosis/Arthritis Program Coordinator

State-Level: 30% Local: 10% Other: 10% Total: 50%

Total Number of Positions Funded: 1

Total FTEs Funded: 0.50

National Health Objective: HO 2-9 Osteoporosis**State Health Objective(s):**

Between 07/2007 and 10/2020, Reduce the rate of hospitalization for vertebral fractures associated with osteoporosis (rate per 10,000 adults aged 65 and older) to 11.5 per 10,000.

Baseline:

14.8 per 10,000 in 2003

Data Source:

Kentucky Hospital Inpatient Discharge and Utilization

State Health Problem:**Health Burden:**

Osteoporosis is a common bone disease that affects all ages and populations. It often goes undetected until a fracture occurs. Osteoporosis is a public health threat for over 44 million Americans, 68% of whom are women. According to the National Osteoporosis Foundation, approximately 14% of all Kentuckians aged 50 and older have osteoporosis, 77% of whom are women. In Kentucky women age 50 and older, 20% (128,000) have osteoporosis and 53% (342,000) have low bone mass. In comparison, data for Kentucky men 50 and older show that 7% (37,300) have osteoporosis and 35% (186,100) have low bone mass. Kentucky's elderly population is projected to nearly double between 2010 and 2030, and will likely increase the burden of osteoporosis-related complications on older adults' lives and Kentucky's healthcare system.

Osteoporosis is often referred to as, "a pediatric disease with geriatric consequences." By age 20, most people have developed their maximum bone density, and they begin losing it in their 30's. Because of this, developing healthy habits early is essential to minimizing osteoporosis risk later in life. Prevention of osteoporosis includes getting the daily recommendations of calcium and Vitamin D, engaging in regular weight-bearing and muscle-strengthening physical activity, and avoiding smoking and excessive alcohol consumption. Yet, in 2007, 67.1 percent of adolescents in 9th through 12th grade did not meet recommended levels of physical activity, 86.8 percent ate fruits and vegetables less than five times per day, and 40.6 percent described current alcohol use. In addition, 25% of high school students and 12% of middle school students reported current tobacco use in 2006.

Osteoporosis is the principal cause of reduced bone strength. One of the most debilitating outcomes from osteoporosis is the greater likelihood of suffering a fracture as the result of a fall. Certain kinds of fractures, specifically hip fractures, are particularly debilitating. Of older adults who suffer a hip fracture, 20% will die within 12 months, and two-thirds will never regain their full level of function experienced prior

to the fracture. Many will be placed in institutional care. In 1996, falls among older adults resulted in \$142 million in charges—93% of which was billed to Kentucky Medicaid for nursing home care.

During the years 2000-2006, 12-18% of individuals who suffered a hip fracture in Kentucky also had a diagnosis of osteoporosis. Kentucky hospital discharge data for 2006 show there were 2,955 discharges of elderly patients with hip fractures from acute and rehabilitation hospitals. Following national trends, females accounted for 75.5% of total hip fracture discharges while males make up 24.5%. It has been estimated that 90% of proximal femur fractures among white women 65-84 years of age are related to osteoporosis. Although the prevalence of hip fracture is less in men, about 80% of male hip fractures are presumed to be osteoporotic-related. Studies show more than 95% of all hip fractures are the result of a fall.

Cost Burden: The estimated national direct care expenditures (including hospitals, nursing homes, and outpatient services) for osteoporotic fractures was \$18 billion per year in 2002. The average cost per patient for treating and caring for a hip fracture within the first year of occurrence is \$26,912. Kentucky 2006 data for age 65 years and older reflect 2,955 admissions to acute care or rehabilitation hospitals for hip fractures. *KY- Minimum cost analyses \$79,524,960-\$80 million for the first year alone post hip fracture. 49% are discharged from the hospital and directly placed in skilled nursing facilities under Medicare payment increasing the cost burden to Medicare.*

Role of Policy: Since the inception of the Osteoporosis Prevention and Education Program in 2006, the focus of the program's efforts have been focused on individual behavior change strategies. The program has come a long way in the ability to offer evidence-based programs that address risk factors for developing osteoporosis as well as risk factors associated with falling. The program is beginning to investigate the role of policy and will continue to move in this direction in the future. Policy initiatives will focus on health across the lifespan (including pediatric/adolescent health through healthy aging), which fits into the Osteoporosis Program's multigenerational perspective.

Target Population:

Number: 4,173,347

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, Asian, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 515,197

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, Asian, White

Age: 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: US Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other:

- National Blueprint: Increasing Physical Activity Among Adults Aged 50 and Older
<http://www.agingblueprint.org/>
- Center for Healthy Aging: Model Health Programs for Communities.
<http://www.healthyagingprograms.org/>
- Bone Health and Osteoporosis: A Report of the Surgeon General
<http://www.surgeongeneral.gov/library/bonehealth/>
- Osteoporosis - Physician's Guide To Prevention and Treatment of Osteoporosis. National Osteoporosis Foundation www.nof.org or <http://www.guideline.gov/>.
- American College of Obstetricians and Gynecologists (ACOG) – Clinical Management Guidelines for Obstetrician-Gynecologists Number 50, January 2004; 103:1.
- A Matter of Balance: Managing Concerns About Falls, Lay Leader Model, Maine Partnership for Healthy Aging http://www.mmc.org/mh_body.cfm?id=432
- The StrongWomen™ Program, John Hancock Center for Physical Activity, Tufts University,
<http://jhccpan.nutrition.tufts.edu/programs/strongwomen> or
http://www.cdc.gov/pcd/issues/2008/jan/06_0165.htm
- Falls Prevention Resources:
 - Preventing Falls: What Works A CDC Compendium of Effective Community-based Interventions from Around the World. <http://www.cdc.gov/ncipc/preventingfalls/>
 - Preventing Falls: How to Develop Community-based Fall Prevention Programs for Older Adults.
<http://www.cdc.gov/ncipc/preventingfalls/>
 - Resource Guide on Building Falls Free Coalitions: <http://www.coalitions.fallsfree.org/>

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$74,120

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$20,000

Funds to Local Entities: \$28,000

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 3 – Inform and Educate

Objective 1:

Bone Health Education

Between 10/2011 and 09/2012, six local health departments will maintain **one** activity for education on fall prevention, osteoporosis, and general bone health through community programs and activities.

Annual Activities:

1. Quarterly Reporting and Evaluation

Between 10/2011 and 09/2012, Each funded local health department or local coalition will provide a written plan and budget for activities and quarterly reporting will be expected.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Safe Aging Coalition

Between 10/2011 and 09/2012, The Kentucky Arthritis/osteoporosis Coordinator when collaborating with the Safe Aging Coalition will distribute the sustainable older adult fall prevention plan for the state to **more**

than 30 coalitions, partners and stakeholders in the state who can have an impact on reducing falls in Kentucky.

Annual Activities:

1. Technical Assistance

Between 10/2011 and 09/2012, Work with the Safe Aging Coalition and UK Injury Prevention and Research Center to provide quarterly technical assistance to five local falls prevention task force groups to assess the community response and resources for older adults who are at risk for falling or who have sustained a fall.

2. Addressing Community Assessments

Between 10/2011 and 09/2012, Work with five local falls prevention task force groups to develop interventions to address gaps found in the community assessment.

3. Fall Prevention Summit

Between 10/2011 and 09/2012, In partnership with the Safe Aging Coalition and UK Injury Prevention and Research Center, hold quarterly Safe Aging Coalition meetings for all stakeholders in Kentucky that addresses the environment and best practices for preventing falls.

Essential Service 5 – Develop policies and plans

Objective 1:

Integrated Policies

Between 10/2011 and 09/2012, the Osteoporosis Program Lead in cooperation with the Healthy Communities Initiative will identify 2 integrated policies that support health across the lifespan and develop plans for educating policy makers.

Annual Activities:

1. Healthy Communities Initiative

Between 10/2011 and 09/2012, the Osteoporosis Program will work with the Healthy Communities Initiative to address policies related to falls prevention, physical activity, nutrition, smoke-free environments and the built environment across the lifespan.

2. Technical Assistance

Between 10/2011 and 09/2012, the Osteoporosis Program will provide technical assistance to the nine local communities chosen for the the Healthy Communities projects.

Objective 2:

Falls Prevention Task Force

Between 10/2011 and 09/2012, the Osteoporosis Program lead, in cooperation with the Safe Aging Coalition, will provide interventions to raise awareness of the impact of falls to two for the elderly.

Annual Activities:

1. Issue Brief

Between 10/2011 and 09/2012, A Falls Prevention Issue Brief will be finalized and distributed to local health departments, providers and made available to the public in cooperation with the Safe Aging Coalition.

2. Task force group work gap analysis

Between 10/2011 and 09/2012, Work with five local falls prevention task force groups to develop interventions that address gaps found in the community assessments.

Essential Service 8 – Assure competent workforce

Objective 1:

Osteoporosis Education and Competency

Between 10/2011 and 09/2012, The Osteoporosis Program will maintain one training module on Osteoporosis. The module is accessible at <http://ky.train.org>.

Annual Activities:

1. Promoting the Osteoporosis Module on TRAIN

Between 10/2011 and 09/2012, Promote the module to local health department staff, aging services, cooperative extension and non-profit organizations through the computer based network system .

2. Training and Technical Assistance

Between 10/2011 and 09/2012, Provide training and technical assistance for implementing evidence-based bone health strategies for local health departments and other community organizations in Kentucky.

Objective 2:

Competency of Trainers

Between 10/2011 and 09/2012, The Osteoporosis Program will maintain 2 training initiatives related to Osteoporosis Prevention and Control.

Annual Activities:

1. Matter of Balance Training

Between 10/2011 and 09/2012, Conduct 10 Matter of Balance participant classes throughout the state and evaluate effectiveness as measured through pre and post surveys.

2. Strong Women

Between 10/2011 and 09/2012, Conduct 12 StrongWomen classes throughout the state and evaluate effectiveness as measured through pre and post surveys.

3. Evaluate and monitor

Between 10/2011 and 09/2012, Conduct quarterly conference calls with Matter of Balance and StrongWomen program leaders in order to monitor success and determine barriers to effective education including review of pre and post surveys and site visits.

State Program Title: Physical Activity Program**State Program Strategy:**

GOAL: The Kentucky Physical Activity Program focuses on increasing the physical activity of adults and children and enhancing the core capacity of health professionals and other partners to participate in planning and development of activities to address community needs.

Priorities: In 2010, the Physical Activity Program along with the Nutrition and Obesity, Tobacco Prevention and Control, Healthy Communities and Worksite Wellness Program was moved in the Department for Public Health into the Division of Maternal and Child Health so that an additional focus could be made on Obesity starting with an upstream approach to families and children.

Beginning in 2001, the PHHSBG Advisory Committee chose to strategically utilize \$1.5 million of the funding received by the state to address the need for increased physical activity in Kentucky. Each of the 56 local/district health departments in the state of Kentucky has received PHHSBG funds in each of those years to address adult and child physical activity within their communities although the PHHSBG funding is considerably less in 2011 than in 2001. Additionally, these funds were for startup funding with the anticipation that programs would create sustainable programs. These mini-grants are given based on their annual community plan which is submitted to the state Physical Activity Program Manager for approval. The community-based plan utilizes pre-approved evidence based strategies and interventions to be conducted by each local health department based on the recommendations in the Guide to Community Services. Each local health department has an assigned coordinator for these projects. Monthly activities at the community level are entered into a statewide Community Health Services Reporting System data base (DataMart); however there are limitations to this data collection system and additional reporting will be necessary to evaluate the impact that this program has on the state.

There is now an integrated approach to Physical Activity in Kentucky. Although strategies can continue to include individual health behavior programs, local health departments have been encouraged to shift to policy, environment and systems change approaches that have much more reach and impact. Local health departments may continue to fund with local and state tax dollars additional strategies beyond those recommended by the Physical Activity Program.

There is a recommendation for Kentucky schools grades K-5 for a minimum supervised recess of 20 minutes daily with the students engaging in 15 minutes of planned moderate to vigorous physical activity each day. This is a recommendation and not a legislated policy. Many districts have placed increased emphasis on healthy school environments and the number of school site based councils who have developed strategies to increase scheduled physical activity throughout the state.

Our best chance of success relies on a coordinated approach involving evidence-based strategies, within settings that span the full range of the social system from school health policies, and local access to physical activities, through health promotion activities and counseling patients by their health care providers.

Primary Strategic Partners:

Internal partners include: Maternal and Child Health, Partnership for a Fit Kentucky, Coordinated School Health, Arthritis/Osteoporosis, Chronic Disease Prevention Branch, Heart Disease and Stroke, Obesity, Diabetes, Coordinated School Health, Nutrition and Health Services Branch.

External partners include: Department of Education, Department of Transportation, Offices of Aging and Independent Living, universities, Foundation for a Healthy Kentucky, Kentucky Medical Association, local and district health departments, YMCAs, faith based organizations and local and city councils.

State Program Setting:

Community based organization, Community health center, Faith based organization, Local health department, Parks or playgrounds, Schools or school district, Senior residence or center, State health department, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO 22-1 Physical Activity in Adults

State Health Objective(s):

Between 07/2003 and 12/2014, Increase to at least fifty percent the proportion of Kentuckians ages 18 and over who engage regularly in physical activity for at least twenty minutes, three or more times per week.

Baseline:

Thirty percent in 2000 with an increase to thirty four percent in 2008. BRFSS data for 2009 indicates 45.7% of adult respondents indicate they engage in regular physical activity.

Data Source:

Kentucky BRFSS data

State Health Problem:

Health Burden:

Lack of physical activity is linked with an increased prevalence of almost all chronic diseases. Data from the 2007 Kentucky Behavioral Risk Factor Surveillance System (BRFSS) indicate that 23% of adults report their health status as being only "fair" or "poor".

Kentucky has the 3rd highest rate of heart disease with almost 6% of the population reporting they have been told by a health care provider that they have coronary heart disease or angina. The diabetes rate is even higher with 9.9% of the population diagnosed. In 2007, only 44% of adult Kentuckians report meeting national guidelines for either moderate or vigorous physical activity; however, that percentage is increased since 1998 in all age categories.

Those with lower levels of education and/or lower income levels are statistically more likely to be less physically active compared to those with a higher education or income level.

On average, physically active people outlive those who are inactive, and maintain functional independence longer. In Kentucky, 28.7% of adults are obese and 35% of adults report they have arthritis. Obesity, lack of physical activity and arthritis are frequently inter-related. Physical activity improves bone health throughout our lifespan and must be emphasized beginning in childhood. Linking the importance of physical activity to bone health positively impacts the health of Kentuckians.

Research also indicates that persons who are sedentary and are not engaged in regular physical activity have higher rates of certain types of cancer such as colon, prostate and breast. Although the leading risk factor by far for cancer is smoking or second hand smoke, physical activity is certainly a modifiable risk factor with linkage to multiple cancers.

Increasing physical activity in all Kentuckians will decrease prevalence and burden of disease as well as improving mobility, quality of life and decreasing the chance of long term disability.

Cost Burden:

It is difficult to measure the actual financial cost of being inactive. However, although there are other factors contributing to obesity, those medical expenses may serve as some indicator of the complexity of the problem. In Kentucky alone, \$1.1 billion was spent in 2003 on medical expenses of those who have been diagnosed as obese. If lack of physical activity related disease and disability could be approximated for Kentucky, the results would likely be disturbing both on a personal level and a state level.

Target Population:

Number: 3,046,951

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, White

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 486,847

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, White

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural

Primarily Low Income: Yes

Location: Specific Counties

Target and Disparate Data Sources: US Census Bureau, KY BRFSS Data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)

Model Practices Database (National Association of County and City Health Officials)

National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: *Core Competencies: Essentials for Public Health Physical Activity
Practitioners

*Physical Activity Guidelines Advisory Committee Report

*Cost Effectiveness of Community Based Physical Activity Interventions:
American Journal of Preventive Medicine

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$100,220

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$56,500

Funds to Local Entities: \$100,220

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 3 – Inform and Educate

Objective 1:

Adult Community Based Physical Activities

Between 10/2011 and 09/2012, the Kentucky Physical Activity Program Manager in collaboration with expert internal and external partners will maintain **two** adult community-based physical activity training opportunities.

Annual Activities:

1. Professional Development

Between 10/2011 and 09/2012, The state physical activity program will provide at least one training opportunity at the Healthy Community annual conference

2. Adult Exercise Programs

Between 10/2011 and 09/2012, Provide funding for Arthritis Foundation Exercise classes and Matter of Balance.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Regional Partnership Coalition Participation

Between 10/2011 and 09/2012, the Kentucky Physical Activity Program Coordinator will increase the percent of local health departments who participate in regional coalitions that effectively address increasing physical activity through policy and environmental change and use of evidence based guidelines from 50 percent to **60 percent**.

Annual Activities:

1. Partnership for a Fit Kentucky

Between 10/2011 and 09/2012, The state Physical Activity Coordinator will provide site visits, list-serve announcements, save the dates, and invitations to local health departments who are not currently involved in regional meetings in order to increase involvement and impact.

2. Second Sunday Initiative

Between 10/2011 and 09/2012, The state Physical Activity Coordinator will provide support and instruction on the Second Sunday Initiative by working collaboratively with local health departments to increase by 10% those communities who agree to close down a road for promoting walking and physical activity in order to promote awareness of environmental and policy change impact.

Essential Service 9 – Evaluate health programs

Objective 1:

Evaluation of Physical Activity Strategies

Between 10/2011 and 09/2012, the Physical Activity Program Coordinator in coordination with the Preventive Health and Health Services Block Grant Coordinator will collect **four** methods of program evaluation for local/district health departments funded through the PHHSBG.

Annual Activities:

1. BRFSS and YRBS Data

Between 10/2011 and 09/2012, the Physical Activity Coordinator will work with the state BRFSS program and the Kentucky Department of Education YRBS survey to analyze the core questions related to exercise, physical activity and access to physical activity on the surveys in order to determine impact across the state of PHHSBG funding.

2. DATAMART activity

Between 10/2011 and 09/2012, Monitor activities of local health departments who input physical activity strategies into DATAMART as a condition of PHHSBG funding.

3. Technical Assistance

Between 10/2011 and 09/2012, The state Physical Activity Program Coordinator will provide technical assistance to local health departments who may need assistance developing, coordinating or completing chosen physical activity strategies. At least 5 sites will be visited annually.

4. Success Stories

Between 10/2011 and 09/2012, Provide training on Success Stories and receive a draft of a success story for each funded health department.

National Health Objective: HO 22-6 Physical Activity in Children and Adolescents

State Health Objective(s):

Between 07/2003 and 12/2014, increase the proportion of young people in grades K-12 who engage in moderate physical activity for at least thirty minutes on five or more of the previous seven days.

Baseline:

18.1 percent in 2003

Data Source:

Kentucky YRBS

State Health Problem:

Health Burden:

Kentucky youth exhibit alarmingly high rates of overweight and risk for adulthood obesity and overweight. Culprits listed in the Kentucky Nutrition and Physical Activity State Plan of 2005 include few children walking to school, daily PE is no longer available in all schools, fast foods are readily available and few healthy food choices for snacks. Sedentary activities such as video games, computer chatting and television have become leisure activities.

For children and youth, the term obesity is not used. Instead, children and youth are said to be "at risk of overweight" or "overweight- comparable to obesity in adults". Different terms are used because children and youth are still growing and their weight/height ratio may change significantly as they grow in height.

Weight and height data is not available for all children in Kentucky. One valid data source comes from children enrolled in the Kentucky WIC program where 17% to 18% of 2-4 year olds are "at risk of overweight" and 16% to 17% of 2-4 year olds are "overweight". In Fayette County where data was collected, 12% of elementary students were "overweight" and 14% were "at risk of overweight".

According to Kentucky 2010 Mid Decade Review only 21.3% of children and adolescents in K-12 engaged in moderate physical activity for 30 minutes at least 5 times a week. Self reported information from the Kentucky Youth Risk Behavior Surveillance Survey for high school students in 2007 indicated 67% of students did not meet recommended levels of physical activity and that 80% did not attend physical education classes daily. The self reported obesity rate was 15.6% as compared to 13.0% nationally for 2007.

Youth are at risk for the all too familiar cycle in Kentucky of lack of physical activity, obesity and the development of chronic disease and disability.

Target Population:

Number: 996,251

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years

Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Number: 203,536
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural
Primarily Low Income: Yes
Location: Specific Counties
Target and Disparate Data Sources: US Census Bureau, KY YRBS and Mid Decade Review

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
Model Practices Database (National Association of County and City Health Officials)
National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: *School Health Index for Physical Activity, Healthy Eating, and a Tobacco
Free Lifestyle: A Self-Assessment and Planning Guide (CDC 2000)
*Coordinated School Health Program (CDC)
*Core Competencies: Essentials for Public Health Physical Activity
Practitioners

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$100,201
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$64,332
Funds to Local Entities: \$100,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 3 – Inform and Educate

Objective 1:

Community Based Training

Between 10/2011 and 09/2012, the Kentucky Physical Activity Program Coordinator will provide training opportunities to **all fifty seven local health departments** who are funded by the PHHSBG.

Annual Activities:

1. Built Environment

Between 10/2011 and 09/2012, The state Physical Activity Program Coordinator will work in collaboration with the Partnership for Fit Kentucky, Healthy Communities Initiative and the Department for

Transportation to develop and distribute evidence based guidelines on the Built Environment to all 57 local and district health departments funded by the PHHSBG.

2. Coordinated School Health Training

Between 10/2011 and 09/2012, The state Physical Activity Program Coordinator In partnership with the Coordinated School Health Program, the Kentucky Dietetics Association and Foundation for Healthy Kentucky, will conduct one professional development in-service on increasing physical activity opportunities for the school Pupil Personnel Directors, Family Resource Youth Service Centers, and local/district health departments.

3. Professional Development

Between 10/2011 and 09/2012, In partnership with the Healthy Communities Initiative provide three video conferences or webinars which can be viewed across the state through a wide network on the transformation to physical activity focused healthy communities.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Regional Partnership Coalition Participation

Between 10/2011 and 09/2012, the Kentucky Physical Activity Program Coordinator will increase the percent of local health departments who participate in regional coalitions that effectively address increasing physical activity through policy and environmental change and use of evidence based guidelines from 50 percent to **60 percent**.

Annual Activities:

1. Partnership for a Fit Kentucky

Between 10/2011 and 09/2012, The state Physical Activity Coordinator will provide site visits, list-serve announcements, save the dates, and invitations to local health departments who are not currently involved in regional meetings in order to increase involvement and impact.

2. Second Sunday Initiative

Between 10/2011 and 09/2012, The state Physical Activity Coordinator will provide support and instruction on the Second Sunday Initiative by working collaboratively with local health departments to increase by 10% those communities who agree to close down a road for promoting walking and physical activity in order to promote awareness of environmental and policy change impact.

Objective 2:

PANTA Plus Manual

Between 10/2011 and 09/2012, the Physical Activity Program, Tobacco Program, Obesity Program, Diabetes Program, Asthma Program, Coordinated School Health and the Kentucky Department for Education will distribute school-based guide book on Physical Activity, Nutrition, Tobacco, and Asthma (PANTA), which was developed in 2006 and was updated in 2010 with new guidelines and resources on evidence based curriculum, best practices, model policies and answers to frequently asked questions, to **50** partners and schools.

Annual Activities:

1. Manual Distribution

Between 10/2011 and 09/2012, Manuals will be distributed to coalitions, schools, and at partnership meetings with a target of engaging each school district and local/district health department in the state.

2. Technical Assistance

Between 10/2011 and 09/2012, Programs that partner in development of the PANTA guide will provide assistance to schools as well as agencies and organizations that partner with schools in designing and planning policies and programs, encouraging environmental change, and promoting overall health of students, staff and the school community.

Essential Service 9 – Evaluate health programs

Objective 1:

Evaluation of Physical Activity Strategies

Between 10/2011 and 09/2012, the Physical Activity Program Coordinator in coordination with the Preventive Health and Health Services Block Grant Coordinator will collect **four** methods of program evaluation for local/district health departments funded through the PHHSBG.

Annual Activities:

1. BRFSS and YRBS Data

Between 10/2011 and 09/2012, the Physical Activity Coordinator will work with the state BRFSS program and the Kentucky Department of Education YRBS survey to analyze the core questions related to exercise, physical activity and access to physical activity on the surveys in order to determine impact across the state of PHHSBG funding.

2. DATAMART activity

Between 10/2011 and 09/2012, Monitor activities of local health departments who input physical activity strategies into DATAMART as a condition of PHHSBG funding.

3. Technical Assistance

Between 10/2011 and 09/2012, The state Physical Activity Program Coordinator will provide technical assistance to local health departments who may need assistance developing, coordinating or completing chosen physical activity strategies. At least 5 sites will be visited annually.

4. Success Stories

Between 10/2011 and 09/2012, Provide training on Success Stories and receive a draft of a success story for each funded health department.

State Program Title: Rape Crisis Centers-Sexual Assault and Domestic Violence Program

State Program Strategy:

Goal: The overall mission of the Rape Crisis Centers (RCCs) in Kentucky is to lessen the negative and often life altering effects sexual violence and assault have on its victims. These centers are statutorily mandated to provide, at a minimum, crisis telephone lines, crisis intervention and counseling, advocacy services, counseling/mental health services, education/consultation services, professional training and volunteer services. The 13 regional RCCs in Kentucky provide services to victim/survivors of sexual assault and their family and friends.

Priorities: Providing access to medical and legal advocacy in the case of sexual assault to all Kentuckians regardless of geographic area, race, sex, ethnicity or any other perceived barriers is the primary priority of the RCCs as supported through the Department for Community Based Services (DCBS), Family Violence Prevention Branch (FVPB) formerly known as the Division of Violence Prevention Resources (DVPR). One additional major function of the centers is to provide professional training for medical and mental health professionals, health department staff and educators. The RCCs also engage in radio spots, public service announcements, and a month-long awareness and prevention campaign during March which is Sexual Assault Awareness Month in Kentucky.

Role of the PHHSBG: Funding from the PHHSBG is allocated to all 13 regional Rape Crisis Centers by the Cabinet for Health and Family Services, DCBS, and FVPB through a contract with the state sexual assault coalition (Kentucky Association of Sexual Assault Programs or KASAP). The PHHSBG supports the advocacy and educational services offered by these regional Rape Crisis Centers in conjunction with any state general funds, federal funds and other private funding streams or grants.

Partnerships:

Internal Partners include the Cabinet for Health and Family Services, Department for Public Health, Division of Women's Health and the Division of Maternal and Child Health, Chronic Disease Prevention Branch, and the Department for Community Based Services.

External Partners include private physicians, hospitals, mental health centers, Regional Abuse councils, the Kentucky State Police and many local justice jurisdictions as well as private organizations.

Evaluation Methodology: Rape Crisis Centers (RCCs) collect a variety of data for their service array. The number of hotline calls related to victimization, the number of new victims seen physically on-site at the RCCs and the number of times advocates are dispatched for medical or legal advocacy needs are a few of the statistical pieces collected at RCCs. Demographic data are also collected to obtain some estimates of location of interpersonal violence per area development district. Data and statistics are calculated from calls to the hotline as well as certain statistics kept by the Kentucky State Police

State Program Setting:

Community based organization, Community health center, Medical or clinical site, Rape crisis center, Schools or school district, Senior residence or center, University or college

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO 15-35 Rape or attempted rape**State Health Objective(s):**

Between 10/2010 and 12/2012, Reduce the rate of forced sexual intercourse or attempted forced sexual intercourse of persons aged eighteen years and older to less than 9.4 per 10,000 persons.

Baseline:

11 per 10,000 persons when this objective was created in 2000.

Data Source:

Kentucky State Police Uniform Crime Report Data.

State Health Problem:**Health Burden:**

Sexual violence is one of the most devastating social problems of our time. It's impact is profound because of the sheer frequency of occurrence, and because of the trauma brought to victims of these crimes. Researchers and clinicians agree that the effect of rape and sexual abuse are physically and psychologically traumatic for victims, and that specialized services should be made available to meet the needs of these clients. According to the US Department of Justice in 1996, only 31% of rapes and sexual assaults were reported to law enforcement officials. In the 2003 study titled "Rape in Kentucky: A Report to the Commonwealth" Dean G. Kilpatrick, Ph.D. and Kenneth J. Ruggiero, Ph.D. found that one in nine women or 175,000 women over the age of eighteen have been the victim of forcible rape sometime in their life.

According to Kentucky State Police data, there was a 26% increase in the number of rapes reported to KY State Police over the period of 2000-2007 (see table below).

Kentucky State Police Crime Report data

<u>Year</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>
Reported Rapes	1,050	1,200	1,124	1,251	1,289	1,292	1,375	1,451	1,567	1,545

In the national 2007 survey "Violence and Victims" it was noted that 60.4% of female and 69.2% of male victims were first raped before age 18. Additionally, the Adverse Childhood Experiences study revealed that experiencing sexual violence as a child is correlated with a variety of negative health consequences later in life such as depression, tobacco use, substance abuse and risk for suicide. Based on national emergency department data, sexual assaults represented 10% of all assault-related injury visits to the emergency department by females in 2006. (CDC National Center for Injury Prevention and Control).

Survivors of sexual violence experience a range of trauma. According to the 2003 article "Mental Health Needs of Crime Victims: Epidemiology and Outcomes" by Kilpatrick, Dean and Aciemo, victims of rape are more likely to develop alcohol related problems and drug abuse related problems. Additionally, 30% contemplated suicide after the incident; 31% sought psychotherapy; 22% took self-defense classes; and 82% said the experience had permanently changed them.

The National Victim Center reported in 1992 that based on the US Census estimates of the number of adult women in the United States, approximately 1.3 million women currently have rape related post-traumatic stress disorder (RR-PTSD) and over 200,000 women will develop RR-PTSD each year. Women have been chosen as the disparate population for Kentucky.

Target Population:

Number: 4,820,100

Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Number: 2,086,702
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: Kentucky State Police Uniform Crime Report

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: "Nine Principles of Effective Prevention Programs": American Psychologist, 2003.
"An Evidence Based Review of Sexual Assault Preventive Intervention Programs" Department of Justice, 2004
Substance Abuse and Mental Health Services Administration (SAMHSA)
Strategies for the Treatment and Prevention of Sexual Assault (AMA)
Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$97,025
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$97,025
Funds to Local Entities: \$97,025
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
Less than 10% - Minimal source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 7 – Link people to services

Objective 1:

Advocacy Services

Between 10/2011 and 09/2012, the thirteen Rape Crisis Centers throughout Kentucky will maintain two methods of advocacy services - legal and medical- for clients at no cost to the victim, their family or friends.

Annual Activities:

1. Medical and Legal advocacy services

Between 10/2011 and 09/2012, Rape Crisis Centers will maintain medical and legal advocacy services at no cost to the client.

2. Hotline Calls

Between 10/2011 and 09/2012, The Rape Crisis Centers will enhance existing outreach methods and provide structure to allow improved access to the crisis hotline which will increase hotline calls by two percent.